Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: TRIUMPH HOSPITAL OF NORTH HOUSTON C/O HOLLOWAY & GUMBERT 3701 KIRBY DR STE 1288 HOUSTON TX 77098-3926	MFDR Tracking #:	M4-03-7599-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: Texas Mutual Insurance Co. Box #: 54	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "It is the position of Triumph Hospital – North Houston that its charges relating to the admission"… "are fair and reasonable charges, that Texas Mutual has employed methods to artificially misrepresent the fair and reasonable value of the services provided and that the balance due as claimed is due and payable as provided for under Texas law."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $6,837.05
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Texas Mutual's payment is consistent with the fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code."… "The Carrier established and explained its method of determining fair and reasonable reimbursement, consistent with 133.30(i), as well as 133.307(i)(1)(F),"… "and has referenced its method in the claim file. Any brief review of this instant dispute or any others involving payment for the same or similar services will reveal the Carrier's consistency in applying its method of determining fair and reasonable."

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
5/31/2002	M, JX, RD, D, 60, O, S, YO, YS, 1*, 5*	Outpatient Surgery	$6,837.05	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - M – "No MAR"
   - D – "Duplicate Bill"
   - O – "Denial after reconsideration"
   - S – "Supplemental payment"

- JX – "Fair and reasonable reimbursement for the entire bill is made on the 'O/R Service' line item."
- RD – "The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(b)"
- 60 – "The provider has billed for the exact services on a previous bill."
- YO – "Reimbursement was reduced or denied after reconsideration of treatment/service billed."
  - 1* – "Fair and reasonable amount allowed for this outpatient surgery is more than the billed amount for revenue 360. Payment of excess paid on revenue 251 and 252."
  - 5* – "Fair and reasonable amount allowed for the outpatient surgery is more than the billed amount for revenue 360. Allowing excess over billed amount on revenue 251 and 252."
- YS – "Supplemental payment"

2. This dispute relates to outpatient surgical services provided in hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011"…

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

4. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)". This request for medical fee dispute resolution was received by the Division on May 27, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on June 25, 2003 to send the additional required documentation. Review of the submitted documentation finds that the requestor's position statement asserts that "its usual and customary fee for the services provided to the Claimant on 05/31/2002 are 'fair and reasonable' charges per Commission Rule 134.401(a)"; however, the requestor did not explain or submit evidence to support the methodology it used to determine the usual and customary fees that it charges for such services. Nor did the requestor submit evidence to support that the charges it billed for the services in dispute are the same as the fees it usually and customarily charges for services that are the same or similar to the disputed services. Further review of the documentation submitted by the requestor finds that the requestor does not discuss or explain how payment of the amount sought would meet the requirements of 28 TAC §134.1 and Texas Labor Code §413.011(d). The requestor has not addressed how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules.

5. Additionally, the Division has found that a reimbursement methodology based upon payment of the hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that:

   > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

   Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.

6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor has not submitted documentation sufficient to meet the requirements of Division rule at 28 Texas Administrative Code §133.307(g)(3)(D). The Division further concludes that the requestor has failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.1, §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.